PIEDMONT COMMUNITY HEALTH PLAN / PIEDMONT COMMUNITY HEALTHCARE

HEALTH BENEFITS CLAIM FORM

Please submit your billing along with this claim form to:
P.O. Box 14408
Cincinnati, OH 45250-0408

Address Change:_____

IMPORTANT: EVERY ITEM MUST BE CHECKED OR ANSWERED BEFORE CLAIM CAN BE PROCESSED

PATIENT

GIVE THE FOLLOWING INFORMATION ABOUT PATIENT

1. Claim is made for:	2. Patient's Name	3. Date of Birth	4. Sex
❒ Husband ❒ Self ❒ Wife ❒ Unmarried ❒ Other _____ Son/Daughter			❒ M ❒ F

5. Full Time Student
Attending _____

Expected Date of Graduation _____

IF DUE TO AN ACCIDENT, ANSWER ITEMS 6-10	6. Date of Accident	7. Place of Accident	8. Was Patient at Work When Accident Occurred? ❒ Yes ❒ No
	9. Briefly Describe Accident		10. Was the accident Due to Someone's Negligence? ❒ Yes ❒ No

EMPLOYEE

GIVE THE FOLLOWING INFORMATION ABOUT OTHER INSURANCE/MEDICARE

11. Any other Medical benefits for employee, spouse, or patient? ❒ Yes ❒ No
If yes, who? ❒ Self ❒ Spouse ❒ Dependent
If Dependent or Spouse, Full Name _____ Date of Birth _____

Coverage Paid Through ❒ Medicare ❒ Medicaid ❒ Other ❒ Employer Sponsored Plan ❒ Private Policy ❒ Champus
Effective Date of Coverage _____
Last Day of Effective Coverage _____

Give Name of Other Insurance Company _____

Phone Number of Other Insurance Company _____

Please Attach Other Insurance Explanation Of Benefits If Applicable

GIVE THE FOLLOWING INFORMATION ABOUT YOURSELF

12. Name (First) (Middle Int.) (Last)	13. Social Security Number	14. Date of Birth 15. Sex ❒ M ❒ F
16. Home Address (Number) (Street) (City) (State) (Zip Code)		

17. Employer Name	18. Company Number	19. Employment Status ❒ Active ❒ Cobra	20. Marital Status ❒ Single ❒ Widowed ❒ Married ❒ Legally Separated ❒ Divorced

21. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any Medical Information Necessary to Process this Claim.

_____
SIGNED DATE

22. AUTHORIZE FOR PAYMENT OF MEDICAL BENEFITS
I herby authorize payment of medical benefits to physician's or supplier's for services billed on this claim.

_____
SIGNED (Insured or Authorized Person)

23. I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT

Employee's Signature _____ Date _____

CLAIMFM

HEALTH BENEFITS CLAIM FORM

TO BE COMPLETED BY PHYSICIAN
(Not required if itemized billing attached)

TYPE OR PRINT

PHYSICIAN SUPPLIER INFORMATION

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)*	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO EMPLOYEE SELF / SPOUSE / CHILD / OTHER	6. EMPLOYEE'S SOCIAL SECURITY NUMBER 8. EMPLOYER AND POLICY NUMBER
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? YES NO B. AN AUTO ACCIDENT? YES NO	11. INSURED'S ADDRESS (*Street, city, state, ZIP code*)
12. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	13. DATE FIRST CONSULTED YOU FOR THIS CONDITION	14. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO
15. DATE PATIENT ABLE TO RETURN TO WORK	16. DATE OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
17. NAME OF REFERRING PHYSICIAN		18. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
19. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*		20. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1.

2.

3.

4.

22. A. DATE OF SERVICE	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	*(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)*	D. DIAGNOSIS CODE	E. CHARGES	F.

23. TOTAL CHARGE	24. TOTAL PAID	25. BALANCE DUE

26. SIGNATURE OF PHYSICIAN OR SUPPLIER SIGNED DATE	27. ACCEPT ASSIGNMENT (Government Claims only) YES NO 30. PHYSICIAN'S SOCIAL SECURITY NO.	28. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
29. YOUR PATIENT'S ACCOUNT NO.		YOUR EMPLOYER I.D. NO.

*PLACE OF SERVICE CODES – THIS NUMBER IS REQUIRED TO BE FURNISHED UNDER AUTHORITY OF LAW

1 - (H) - INPATIENT HOSPITAL
2 - (OH) - OUTPATIENT HOSPITAL
3 - (O) - DOCTOR'S OFFICE
4 - (H) PATIENT'S HOME
5- DAY CARE FACILITY (PSY)
6- HOME CARE FACILITY (PSY)
7 - (NH) - NURSING HOME
8 - (SNF) SKILLED NURSING FACILITY
9 - AMBULANCE
O - (OL) - OTHER LOCATIONS
A - (IL) INDEPENDENT LABORATORY
B - OTHER MEDICAL/SURGICAL FACILITY